

Jefferson-Pilot
Life Insurance Company
P.O. Box 21008
101 North Elm Street
Greensboro, North Carolina 27420

This Policy Provides Disability Income Coverage
And Is Non-Cancellable And Guaranteed Renewable
To Age 65 Without Change In Premium

Jefferson
Pilot

(Called Jefferson-Pilot in this Policy)

Jefferson-Pilot hereby insures you against loss due to Total Disability as defined herein and to the extent provided in this policy. All of the provisions on this and the following pages are a part of this policy.

**NONCANCELLABLE AND GUARANTEED RENEWABLE
TO AGE 65 AND CONDITIONALLY RENEWABLE
THEREAFTER TO AGE 70**

Until the end of the policy term on or after you become age 65:

- (1) you have the right to renew this policy by payment of the premium when due;
- (2) Jefferson-Pilot cannot cancel this policy for any reason;
- (3) Jefferson-Pilot cannot change the premium rate.

You can continue this policy after age 65, if you are regularly employed at least 30 hours per week, but not beyond the policy term on or after your 70th birthday. Premiums payable after your 65th birthday will be based on Jefferson-Pilot's rates then in effect for your age, sex and occupation.

If Jefferson-Pilot accepts a premium after age 70, this policy will stay in force until the end of the period that premium covers.

NOTICE — PLEASE READ

This policy was issued on the basis of information furnished in your application. A copy of your application is attached. It is part of the policy. Write to Jefferson-Pilot Life Insurance Company at Greensboro, North Carolina, if:

- (1) To the best of your knowledge and belief any information shown on your application is not correct and complete; or
- (2) Any information in regard to your medical history has been left out.

NOTICE OF TEN DAY RIGHT TO EXAMINE POLICY

This policy is a legal contract between you and Jefferson-Pilot. Read it carefully. If this policy is returned to Jefferson-Pilot or any Jefferson-Pilot agent or agency within 10 days after it is received, all premiums paid will be refunded. The policy will be void from the beginning.

WJ-576A

READ YOUR POLICY CAREFULLY

SMITH MEN

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AEN

Total Disability means during the first 5 years of a period of total disability that, because of Sickness or Injury, you are:

- (1) unable to perform the substantial and material duties of your occupation; and
- (2) you are not actually engaged in any other occupation.

After you have been totally disabled for a period of 5 years, you will be considered totally disabled if you are unable to perform the duties of any occupation for which you are qualified by education, training or experience, with due regard to your earnings before disability started.

You And Your means the Insured named in the Schedule.

Elimination Period means a number of days at the beginning of a Period of Total Disability during which no benefits will be paid under this policy. The Elimination Period is shown in the Schedule.

Maximum Benefit Period means the maximum time for which benefits will be paid for any one Period of Total Disability.

Doctor means any medical practitioner other than yourself that is:

- (1) duly licensed under applicable law; and
- (2) acting within the scope of his license.

Period of Disability means a period of Total Disability which begins on the date you are first treated by a Doctor or cease employment, whichever is later, and ends on the last date you are treated by a Doctor or resume employment, whichever is earlier.

Military Service means service that is scheduled for or actually lasts for more than 60 days in a row in any army, navy, air force, marine corps, coast guard or any other military branch of any country or combination of countries.

Sickness means sickness or disease which is first manifested after the effective date of this policy and while this policy is in force.

Injury means bodily injury sustained in an accident which occurs while this policy is in force.

Monthly Benefit means the amount shown in the Schedule or 1/30 of such amount for each day of any Period of Total Disability that does not equal a whole month.

War means any act of war, whether declared or undeclared.

The Care of a Doctor means medically necessary care and treatment of the Sickness or Injury causing disability. Care is not required after it is medically determined that further medical care or treatment will not alleviate your disability.

BENEFIT PROVISIONS

Benefits for Total Disability Due to Injury

If Injury results in continuous Total Disability, Jefferson-Pilot will pay the Monthly Benefit as shown in the Schedule for each month during a Period of such Total Disability which:

- (1) begins while this policy is in force;
- (2) is longer than the Elimination Period;
- (3) begins not later than 90 days after the date of the accident in which the Injury is sustained;
- (4) requires that you be under the Care of a Doctor; and
- (5) does not exceed the Maximum Benefit Period for Injury shown in the Schedule.

However, a Period of Total Disability due to Injury will be considered to result from Sickness with benefits payable as such if the Period of Total Disability begins more than 90 days after the date of the accident in which the Injury was sustained.

Benefits for Total Disability Due to Sickness

If Sickness results in continuous Total Disability, Jefferson-Pilot will pay the Monthly Benefit as shown in the Schedule for each month of a period of such Total Disability which:

- (1) begins while this policy is in force;
- (2) is longer than the Elimination Period;
- (3) requires that you be under the Care of a Doctor; and
- (4) does not exceed the Maximum Benefit Period for Sickness shown in the Schedule.

In no event will benefits be payable for both Injury and Sickness at the same time.

Increase in Benefits

After you have received benefits for Total Disability for 12 consecutive months, your Monthly Benefit will be increased during the continuance of that Period of Disability up to your

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65th birthday. The increase will be 3% of the Monthly Benefit shown in the Schedule for each successive 12 month Period of Total Disability after the first Period. The benefit payable will not be increased for the part of any Period of Total Disability beyond your 65th birthday.

The Monthly Benefit paid for each separate Period of Total Disability will be the amount of Monthly Benefit shown in the Schedule subject to increases for that Period as indicated above.

Recurring Disabilities

You may have more than one Period of Total Disability. If a Period is due to the same or related causes and begins while this policy is in force, it will be considered a continuation of the prior Period unless:

- (1) a Monthly Benefit was not payable for the prior Period, or
- (2) the Periods are separated by at least 6 consecutive months throughout which you were employed full time in your regular occupation.

Loss of Sight, Speech or Use of Two Members

If as a result of Injury or Sickness you suffer the total and irrecoverable loss of the sight of both eyes, speech, or use (by severance or otherwise) of both hands, feet, or one hand and one foot, (in a policy issued to a resident of South Carolina, loss of hands means the loss of four fingers entire) Jefferson-Pilot will:

- (1) waive the Elimination Period and medical care requirement; and
- (2) pay the applicable Monthly Benefit even though you may continue to be employed.

However, you may not receive benefits for such loss if you are eligible for benefits under any other provision of this policy.

Surgical Transplant

You may become Totally Disabled from the transplant of part of your body to the body of another. Jefferson-Pilot will consider such Total Disability as resulting from Sickness if the transplant occurs:

- (1) while this policy is in force; and
- (2) at least 6 months after the Effective Date.

However, you will not receive benefits for Total Disability due to a transplant if you are eligible for benefits under any other provision of this policy.

Waiver of Premium

If you become Totally Disabled for a continuous period of at least 3 months Jefferson-Pilot will:

- (1) waive premiums that come due during the disability; and
- (2) refund any payments made for premiums due during the disability.

Jefferson-Pilot will continue to waive premiums under this policy until you are no longer Totally Disabled or benefits are no longer payable, whichever is earlier. But no premium due on or after your 65th birthday will be waived or refunded.

While premiums are waived, this policy stays in force even though you do not pay premiums. Once premiums are no longer waived, this policy stays in force until the next premium due date. At that time premiums again become payable.

LIMITATIONS AND EXCLUSIONS

There are some disorders that will be considered caused by Sickness instead of by Injury for the purpose of Total Disability. The following may entitle you to Total Disability due to Sickness and not Injury:

- (1) disease or medical or surgical treatment of a disease;
- (2) infection, other than an infection that causes pus to form and is caused by an accidental cut or wound; and
- (3) any kind of hernia, however caused.

This policy does not cover any loss caused by:

- (1) War;
- (2) self-inflicted Injury that is intentional;
- (3) any Injury or Sickness occurring while you are in the Military Service (other than active duty for training purposes only for less than 60 days);
- (4) normal pregnancy or resulting childbirth.

SUSPENSION DURING MILITARY SERVICE

Jefferson-Pilot will suspend this policy if you enter Military Service, except for training purposes for 2 consecutive months or less. However, you must request it in writing to Jefferson-Pilot. Jefferson-Pilot will refund, on a pro-rata basis, any premiums you paid during a period you were not covered because of active Military Service.

If your active duty is less than 5 years, you may reinstate this policy.

You must make a written request to Jefferson-Pilot for reinstatement:

- (1) within 60 days after your release; and
- (2) pay the pro-rata premium. The pro-rata premium should cover the time since your release until the premium due date that next follows the date your request is received.

You will not have to prove you are still insurable.

GENERAL PROVISIONS**Consideration, Effective Date, Term:**

This policy is issued in consideration of:

- (1) the application which is a part of this policy; and
- (2) the payment of the Initial Premium shown in the Schedule.

The effective date shown in the Schedule is:

- (1) the date on which the policy becomes effective and coverage begins; and
- (2) the date from which the policy term commences.

Coverage lasts for the Term shown in the Schedule and renewal premiums are due at the beginning of each successive Term. The policy is renewable as provided in the renewal provision on the face page.

Entire Contract: Changes:

This policy with the application and attached papers, if any, is the entire contract between you and Jefferson-Pilot. No change in this policy will be effective until approved by an Executive Officer of Jefferson-Pilot. This approval must be attached to this policy. No agent may change this policy or waive any of its provisions.

Incontestability:

- (1) Jefferson-Pilot relies on the statements you make in your application. Jefferson-Pilot will not contest those statements after this policy has been in effect for 2 years during your lifetime. Any length of time you are disabled is excluded in computing this 2 year period.
- (2) If disability starts or a loss is incurred more than 2 years after the Effective Date, Jefferson-Pilot will not reduce or deny the claim on the ground that a Sickness or physical condition existed before this policy's effective date. This does not apply to any Sickness or physical condition excluded from coverage by name or specific description.

Grace Period:

This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

Reinstatement:

If a renewal premium is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by

Jefferson-Pilot (or by an agent authorized to accept payments), without requiring an application for reinstatement, will reinstate the policy. If an application is required by Jefferson-Pilot or such agent, you will be given a conditional receipt for the premium paid. If the application is approved, the policy will be reinstated as of the approval date. If it is disapproved, Jefferson-Pilot will inform you in writing within 45 days after the date of the conditional receipt. Failure to so inform you will result in the policy being reinstated upon such 45th day.

The reinstated policy will cover only loss due to Injury sustained after the date of reinstatement or Sickness which begins more than 10 days after the date of reinstatement. In all other respects your and Jefferson-Pilot's rights will remain the same as they were just before the policy lapsed, subject to any riders or endorsements added at the time of reinstatement.

Notice of Claim:

Written notice of claim must be given within 30 days after any covered loss starts or soon afterwards as is reasonably possible. The notice can be given to Jefferson-Pilot at its Home Office, or to Jefferson-Pilot's agent. Notice given by or for you with your name or policy number and address shall be considered notice.

Claim Forms:

When Jefferson-Pilot receives the notice of claim, it will send you forms for filing proof of loss. If the forms are not sent to you within 15 days, you will meet the proof of loss requirement if you give Jefferson-Pilot a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

Proofs of Loss:

Written proof of loss must be given within 90 days after the end of each period for which Jefferson-Pilot is liable for periodic payments for a continuing loss. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Jefferson-Pilot shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless you were legally incapacitated.

Time Payment of Claims:

As soon as written proof of disability is received, Jefferson-Pilot will pay monthly all benefits then due for which Jefferson-Pilot is

liable. Benefits for any other loss covered by this policy will be paid as soon as Jefferson-Pilot receives proper written proof.

Payment of Claims:

While you are alive, all benefits will be paid to you. Any accrued benefits unpaid at death will be paid to your beneficiary or estate.

If benefits are payable to your estate or a beneficiary who can not execute a valid release, Jefferson-Pilot can, at its option, pay benefits up to \$1,000 to:

- (1) someone related to you; or
- (2) someone related to your beneficiary by blood or marriage whom Jefferson-Pilot considers to be entitled to the benefits.

Jefferson-Pilot will be fully discharged to the extent of any such payment made in good faith.

Physical Examinations and Autopsy:

Jefferson-Pilot has the right to have you examined as often as reasonably necessary while a claim is pending. Any such examination will be at Jefferson-Pilot's expense. It may also have an autopsy made unless prohibited by law.

Legal Actions:

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years (6 years in South Carolina and Kansas) from the time written proof of loss is to be given.

Misstatement of Age:

If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age. If no coverage would have been issued, Jefferson-Pilot will refund the premium paid.

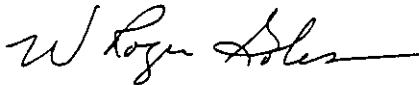
Conformity with State Statutes:

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date is amended to conform to the minimum requirements of such laws.

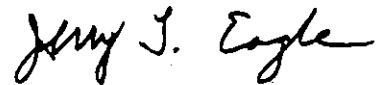
Refund of Premium at Death:

Jefferson-Pilot will refund that part of any premium paid which covers a period after your death except a premium which has been waived.

IN WITNESS WHEREOF Jefferson-Pilot Life Insurance Company has caused this policy to be signed by its Chairman of the Board and Chief Executive Officer and its Secretary.



Chairman of the Board
Chief Executive Officer



Secretary

Countersigned by
(When Required in State of Residence)

Licensed Resident Agent

STAMPED: MEN

INDIVIDUAL HEALTH INSURANCE ADMINISTRATION DEPARTMENT — 417
GREENSBORO, NORTH CAROLINA 27420

APPLICATION FOR:

- ☒ Deletion or Modification of Exclusion Rider
☐ Reduction or Removal of Extra Premium Rating Rider

H493029

1. Insured's Name CHRISTOPHER L. KEARNEY Policy No. H00538069
2. Excluded or Rated Condition BACK RIDER

(ANSWER ONLY FOR PERSON TO WHOM THE CONDITION APPLIES)

3. Has complete recovery from the condition been experienced? ☒ Yes ☐ No
4. Has any medical attention or advice been received for the condition since the date the Rider was included in the policy? (If "Yes", give dates received and names and addresses of physicians.) ☐ Yes ☒ No
5. Since the date of the Rider, has any medical attention or advice been received for any condition other than the excluded condition? (If "Yes", give full details including names and addresses of physicians, reasons and dates consulted, and results) ☐ Yes ☒ No

The statements in this application are mine and are true and complete to the best of my knowledge and belief. I agree that they shall be the basis for any change or modification of the Rider referred to above and currently attached to the policy.

For purposes of underwriting the insurance specified herein, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of any of the proposed insureds or their health, to give to Jefferson-Pilot Life Insurance Company, its reinsurers and any consumer reporting agency acting on its behalf, any such information. This authorization shall remain valid for 30 months from the date it is signed. Either I or my authorized representative is entitled to receive a copy of this disclosure authorization. A photographic copy of this authorization shall be as valid as the original.

I have received and read the "Notice" regarding the M.I.B. disclosure; Public Law 91-508; and the disclosure of information practices. If an Investigative Consumer Report is required, do you request a personal interview? ☐ Yes ☐ No

Date 3/16, 19 92 Insured's Signature Christopher Kearney
Licensed Resident Agent Daniel D. Mann

HOME OFFICE USE ONLY

POLICY AMENDMENT

In consideration of the Insured's application above, which is hereby made a part of the policy, the Rider below is amended by the deletion of the name or description of the condition(s) reading: Backach, back strain, and/or any disease or disorder of the back or spine, or any complication thereof.

and the substitution of the following therefor: None

AMENDMENT

Any conditions named or described in the Rider identified below but not specifically herein amended shall remain as stated therein. This amendment takes effect as of the Amendment Date and is subject to all of the provisions, conditions, exceptions, limitations and other terms of the policy not inconsistent herewith. This amendment shall not vary, alter or extend the provisions of the policy or any Rider except as specifically set forth herein.

Amendment to Rider W— J793 dated 5-28-91 and attached to Policy No. H-538069
Amendment Date 05-05-92

JEFFERSON-PILOT LIFE INSURANCE COMPANY

[Signature]
VICE PRESIDENT

Signature of authorized official Date

SCHEDULE

	FOR TOTAL DISABILITY DUE TO: INJURY	SICKNESS
MONTHLY BENEFIT	\$1,375.00	\$1,375.00
ELIMINATION PERIOD	90 DAYS	90 DAYS
MAXIMUM BENEFIT PERIOD *		
FOR A PERIOD OF CONTINUOUS TOTAL DISABILITY COMMENCING:		
-BEFORE THE ANNIVERSARY DATE OF THIS POLICY NEXT FOLLOWING YOUR 45TH BIRTHDAY	LIFETIME	LIFETIME
-ON OR AFTER THE ANNIVERSARY DATE OF THIS POLICY NEXT FOLLOWING YOUR 45TH BIRTHDAY AND BEFORE THE ANNIVERSARY DATE OF THIS POLICY NEXT FOLLOWING YOUR 63RD BIRTHDAY	AGE 65	AGE 65
-ON OR AFTER THE ANNIVERSARY DATE OF THIS POLICY NEXT FOLLOWING YOUR 63RD BIRTHDAY	24 MONTHS	24 MONTHS

*UNLESS THE MAXIMUM BENEFIT PERIOD IS 'LIFETIME', THE MAXIMUM BENEFIT PERIOD FOR ANY PERIOD OF TOTAL DISABILITY BEGINNING PRIOR TO THE ANNIVERSARY DATE OF THIS POLICY NEXT FOLLOWING YOUR 63RD BIRTHDAY WILL NOT EXTEND BEYOND THE ANNIVERSARY DATE OF THIS POLICY NEXT FOLLOWING YOUR 65TH BIRTHDAY.

ADDITIONAL BENEFIT PROVISIONS INCLUDED, IF ANY:

WJ1527A SOCIAL SECURITY SUPPLEMENT BENEFIT \$225.00
WJ1817 RESIDUAL DISABILITY
W1756 COST OF LIVING INCREASE

STIMEN

INSURED CHRISTOPHER L KEARNEY

POLICY NUMBER H0-0538069

TERM: 12 MONTH(S)

EFFECTIVE DATE MAY 28, 1991

PREMIUM FOR EACH TERM UNTIL
AGE 65** \$709.26

**NOTE: RENEWAL OF COVERAGE BEYOND AGE 65 MAY REQUIRE AN INCREASE IN THE RENEWAL PREMIUM AFTER AGE 65

WJ1413A

Check Mail Address	1. Proposed Insured (print)	First	Middle	Last	Birth Date	Age	Height	Weight	Birthplace
	2. Resident Address	Street	City	County	State	Zip	Sex	Marital Status	Soc. Sec. No.
	3. Occupation and Duties (state position or title and duties performed)	Class				Duration of Present Employment			
	4. Employer	Type of Business				Bus. Address:			

5. A. What is your average earned monthly income (net, if self employed)? \$7560.00
B. Does your employer have a formal salary continuance plan? ☒ Yes ☐ No
If "Yes" how long will salary be continued? To 65

6. Do you understand and agree that under the terms of the insurance hereby applied for, no benefit for loss of time is payable for the first 90 days of any period of disability? ☒ Yes ☐ No

7. What accident or disability insurance do you have in force or applied for in all companies (including Life, Group and State Disability Income benefits)? If none check here ☐

Company	Monthly Indemnity	Indemnity Period	To Be Replaced?
<u>JP</u>	<u>\$2750</u>	<u>To 65</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

8. Beneficiary (if policy contains Surrender Value)
Full Name Yoshiko Kearney
Relationship Wife

9. Have You Within the past 5 years:
A. had any Accident, Health or Life insurance modified, postponed, rated, declined, or renewal refused? ☒ Yes ☐ No
B. made claim for or received payment for any injury or sickness from an insurance company, a governmental agency or other source? ☒ Yes ☐ No

Complete if Medical Examination (Part II) is not required:

10. Have you been treated for or had any indication of, within the past 10 years, any disease or disorder of the:
- | | Yes | No |
|--|--------------------------|-------------------------------------|
| A. Brain or Nervous System? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| B. Heart, Lungs, Pleurae or Chest? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| C. Digestive Tract, Liver, Kidneys or Bladder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| D. Skin, Middle Ear, Eyes, Nose or Throat? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
11. Within the past 10 years, have you:
- | | Yes | No |
|--|--------------------------|-------------------------------------|
| A. Had high or low blood pressure? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| B. Had Rheumatism, Back or Joint Disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| C. Had Cancer, Gout, Tumor or Growth? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| D. Had an accident or injury? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| E. Undergone a surgical operation? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| F. Been a patient in a hospital or institution? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| G. Had Tuberculosis, Nervous Disorder or Diabetes? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| H. Had an operation advised but not performed? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
12. Within the past 5 years, have you:
- | | Yes | No |
|---|--------------------------|-------------------------------------|
| A. been treated for any sickness, disease or injury not stated elsewhere in this application? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| B. had any indication or symptoms of a disease or disorder not listed in Questions 10 and 11? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
13. Have you had a physical check-up within the past 2 years? ☐ Yes ☒ No
14. Are you taking any medication or treatment, or on any special diet? H538069 ☐ Yes ☒ No
15. Give full details on lines below about "Yes" answers to questions 9 through 14.

Ques. No.	Nature of Disorder or Injury; Reason	Dates and Duration	Present Condition	Names and Addresses of Doctors, Hospitals and Insurance Companies
9A	BACK sprain Riddled	11/89 to 3/90	Recovered	Ambrose Pesciuk D.C. 11071 MAIN ST Cincinnati, OH 45241
SPECIMEN				

Each of the foregoing answers is correctly written, as given by me, and is true and complete to the best of my knowledge and belief. I agree that issuance of a policy shall be based on said answers recorded above and that no insurance shall take effect unless a policy is issued and accepted by me and the full first premium thereon is paid.

I have received and read the "Notice" regarding the M.I.B. disclosure; Public Law 91-508; and the disclosure of information practices. If a Investigative Consumer Report is required, do you request a personal interview? ☐ Yes ☐ No

Christopher Kearney Dated at Cincinnati, OH Date 4/8 19 91
Signature of Proposed Insured Agent's Certification

I hereby witness the proposed insured's signature. I certify that the answers to the above questions were recorded as supplied by him.
Daniel D. Norris DD NORRIS 1014860 71542
Agent's Signature Agent's Name (Print) Agent's No. Agency or District

Proposed insured must sign Medical Disclosure Authorization on reverse side.

Medical Disclosure Authorization

For the purpose of underwriting this application for Insurance, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of the proposed insured or their health to give Jefferson-Pilot Life Insurance Company and it's reinsurers such information. I also authorize the foregoing, except for the Medical Information Bureau, to give such information to any Consumer Reporting Agency acting on behalf of Jefferson-Pilot. I further authorize Jefferson-Pilot Life to give all such information to my personal physician upon request and I waive any privilege to such information. This authorization shall be valid for 30 months from this date and either I or my authorized representative may obtain a copy of this authorization. A copy of this authorization shall be as valid as the original.

Signature Christopher L. Kary Date 4/8/91 Signature David D. Thomas
Proposed Insured Agent

Complete Only if Proposed Insured is a Resident of the State of Virginia

The undersigned Proposed Insured and agent certify that the Proposed Insured has read, or had read to him, the completed application and that he realizes that any false statement or misrepresentation therein may result in loss of coverage under the policy.

Signature _____ Date _____ Signature _____
Proposed Insured Agent

Benefits Applied For — Agents Use — Show only benefits available on Policy applied for:

Policy Form <u>WT 576</u>	Monthly Benefit <u>\$ 1375.00</u>	Elimination Period <u>90</u> days	Benefit Period Acc. <u>65</u> Sick <u>65</u>	Temporary Additional Benefit During 1st year of Disability \$		
Total Premium <u>\$ 59.36</u>	Social Security Benefit <u>\$ 225.00</u>	Residual Disability Benefit <input checked="" type="checkbox"/> Yes	Surrender Value Benefit <input type="checkbox"/> Yes	Surrender Option <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV		Monthly Amount \$
MODE <input type="checkbox"/> AN <input type="checkbox"/> QR <input type="checkbox"/> DT <input type="checkbox"/> SA <input type="checkbox"/> MO <input type="checkbox"/> SS		Guaranteed Insurability <input type="checkbox"/> Yes Premium \$		Partial Disability Benefit <input type="checkbox"/> Yes		
AMT. REMITTED <u>59.36</u>	Other (Specify) <u>4% INCREASE IN BENEFITS</u>		Other (Specify)		Sex <u>M</u>	Class <u>38</u>
					Age <u>38</u>	

Agent's Statement — Complete In All Cases

(1) Did the applicant approach you for this application? (If "yes" give details under remarks)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	(8) If premium is to be paid on a bank draft, is a completed authorization and sample check enclosed?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
(2) Did you give the applicant an Outline of Coverage or description of the policy?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	(9) Is this part of a mass billing plan? (If "yes" show case number and proposed effective date below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
(3) Has the initial premium been paid and a conditional receipt been given the applicant?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	(10) Please indicate applicant's telephone Number where he or she can be reached during the day <u>513-7911185</u>	
(4) Do you know of any reason the application should not be favorably considered?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Remarks <u>Employer paid premium</u>	
(5) Is a concurrent application for Life Insurance been submitted?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
(6) Is Third Party Ownership desired? (If "yes" complete Form WJ-1713)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
(7) Does Proposed Insured have aviation activities other than as a passenger? (If "yes" complete Form WJ-1713)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

- 1 a. Name and address of your personal physician? Dr. H. Berninger 1004 Oregonia Lebanon OH 45036
b. Date and reason last consulted? 12/90 - Cerumen
c. What treatment was given or medication prescribed? - Cerumen removed
- 2 Have you, within the past 10 years, been treated for or had any known indication of:
- | | Yes | No | Details of "Yes" answers. (Identify question number, circle applicable items: Include diagnoses, dates, duration, names and addresses of all physicians and medical facilities.) |
|--|-------------------------------------|-------------------------------------|--|
| a. Disorder of eyes, ears, nose or throat? <u>See above</u> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| b. Dizziness, fainting, convulsions, headache, paralysis or stroke; mental or nervous disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| c. Shortness of breath, persistent hoarseness or cough, asthma, bronchitis, pleurisy, emphysema, tuberculosis or chronic respiratory disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 22 "1987" food poisoning not hospitalized
Dr. Berninger et al |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart attack, murmur or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 24 1987 - Leishmania 1-2 wks
Dr. Berninger referred to urologist Dr. Melick
10580 Montgomery Rd.
Cmtn OH 45242
Dr. J. Garfield 10475 Montgomery
Cmtn OH 45242 |
| e. Jaundice, intestinal bleeding, ulcer, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 24 10-89 - low back strain
Saw Chiropractor |
| f. Sugar, albumin, blood or pus in urine, sexually transmitted diseases, stone or other disorder of kidney, bladder or prostate? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 21 sebaceous cysts removed
5d X-ray back by Chiropractor |
| g. Diabetes, thyroid or other endocrine disorders? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 7 89 - Workmen's Comp.
for low back 3-4 mos |
| h. Neuritis, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 9 Father had coronary
bypass surg (and)
hypertension |
| i. Deformity, lameness, or amputation? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| j. Disorder of skin, lymph glands, cyst, tumor or cancer? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| k. Allergies, anemia or other disorder of the blood? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| l. Need for treatment because of alcohol or drug abuse? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| m. Abnormalities, disease or disorder of the reproductive organs or breasts, menstruation or pregnancy? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
- 3 Are you now under observation or taking treatment? ☐ ☒
- 4 Have you had any change in weight in the past year? ☐ ☒
- 5 Other than the above, have you within the past 5 years:
- | | Yes | No |
|---|-------------------------------------|-------------------------------------|
| a. Had any mental or physical disorder not listed above? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Had a checkup, consultation, illness, injury or surgery? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanatorium or other medical facility? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d. Had electrocardiogram, X-ray, or other diagnostic test? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- 6 Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? ☐ ☒
- 7 Have you ever requested or received a pension, benefits or payment due to an injury, sickness or disability? ☒ ☐
- 8 To the best of your knowledge and belief are you now pregnant? ☐ ☒
- 9 Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, alcoholism or suicide? ☒ ☐

Parents	Age if Alive	Age at Death	Cause of Death	Siblings	Age if Alive	Age at Death	Cause of Death
Father	74			7 Brothers	oldest 73		
Mother	68			3 Sisters	youngest 28		

The answers to the above questions are to the best of my knowledge complete, true and written as I gave them.

For the purpose of underwriting this application for life insurance, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of the proposed insureds or their health to give Jefferson-Pilot Life Insurance Company and its reinsurers such information. I also authorize the foregoing, except for the Medical Information Bureau, to give such information to any consumer reporting agency acting on behalf of Jefferson-Pilot Life. I further authorize Jefferson-Pilot Life to give all such information to my personal physician upon request and I waive any privilege to such information. I understand either I or my authorized representative may obtain a copy of this authorization. This authorization shall be valid for 30 months from this date and a copy of this authorization shall be as valid as the original.

Cincinnati OH 5-28-91
City and state where signed Date

1021 JUN -3 AM 10:00

Christopher L. Kearney
Signature of proposed insured (if under age 15, parent)
Signature of Examiner
M.D.

BJ-3887C

Medical Examiner's Report for		Males Only			Details "Yes" answers.	
10. a. Height (in shoes) 5 ft. 11 in.	Weight (Clothed) 166 lb.	Chest (full Inspiration) 40 in.	Chest (Forced Expiration) 38 in.	Abdomen at Umbilicus 33 in.		
					Yes	No
b. Was proposed insured weighed?					<input checked="" type="checkbox"/>	<input type="checkbox"/>
c. Was proposed insured measured?					<input checked="" type="checkbox"/>	<input type="checkbox"/>
d. Is appearance unhealthy, or older than stated age?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. BLOOD PRESSURE: If initial reading exceeds 140 systolic or 90 diastolic, re- take later in examination. Record All Readings.						
FIRST READING		ADDITIONAL READINGS				
Systolic	130					
Diastolic	70					
a. PULSE: RATE EXTRA OR DROPPED BEATS PER MINUTE						
(1) At rest	84	0				
(2) Immediately after exercise	130	0				
(3) Three minutes after exercise	78	0				
STATE TYPE OF ARRHYTHMIA:						
12. HEART:						
a. Are the heart sounds normal?					Yes	No
Is there any evidence of:					<input checked="" type="checkbox"/>	<input type="checkbox"/>
(1) Cardiac enlargement?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(2) Arteriosclerosis?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. If heart murmur is heard, answer following questions:						
(1) where is it best heard?						
(2) is it systolic, diastolic or presystolic?						
(3) is it constant?						
(4) is it transmitted?						
(5) diagnosis of heart condition?						
13. Is there on examination any abnormality of the following:						
(a) eyes, ears, nose, mouth, pharynx?					Yes	No
(if vision or hearing markedly impaired, indicate degree and cor- rection)					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(b) skin (include scars); lymph nodes; varicose veins or peripheral arteries?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(c) nervous system (include reflexes, gait, paralysis)?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(d) respiratory system?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(e) abdomen (include scars)?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(f) genitourinary system (include prostate)?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(g) endocrine system (include thyroid and breasts)?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(h) musculoskeletal system (include spine, joints, amputations, deformities)?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Are there any hernias?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. Are you aware of additional medical history?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
(A confidential report may be sent to the Medical Director)						
Urinalysis:	Albumin	Sugar	Send specimen to Home Office if: (1) proposed insured has hyperten- sion or diabetes; (2) either albumin or sugar are present or have been found in the past; (3) application is for \$100,000 or more.			
Is specimen being sent to Home Office?		Yes		No		
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		

I certify that I made this examination at 4 o'clock ☐ A.M. ☒ P.M. on the 28th day of May, 1997

Lawrence Esser
Examiner's Signature M.D.

Greensboro, North Carolina
EXCLUSION RIDER — INDIVIDUAL

Insured Christopher L. Kearney Policy No. H-538069 Rider Date 05-28-91

In consideration of the issuance or reinstatement of the policy identified above and in view of prior medical history of the Insured it is agreed that, notwithstanding anything in the policy to the contrary, with respect to the Insured the said policy shall not provide benefits under any of its provisions and no payment shall be made for loss resulting from or caused or contributed to by:

Backache, back strain, and/or any disease or disorder of the back or spine, or any complication thereof.

This rider takes effect as of the rider date, subject to all provisions, conditions, exceptions, limitations, and other terms of the said policy not inconsistent herewith and to the acceptance by the Insured as provided hereon.

JEFFERSON-PILOT LIFE INSURANCE COMPANY

Henry J. Egle

Secretary

Countersigned at

Cincinnati, OH

by

Danell D. Davis C.L.U.
Licensed Resident Agent

The terms of the above rider are acceptable to me. I agree that the same shall be a part of the policy referred to in said rider and to attach a copy thereof to said policy.

Christopher Kearney
Insured

To be signed in duplicate, the original to be attached to policy and the duplicate to be sent to the Company.

JEFFERSON-PILOT LIFE INSURANCE COMPANY

For Disability Income Premium Discount

Proposed
InsuredChristopher

First

L

Middle

(please print)

KEARNEY

Last

1. Within the past 12 months have you smoked cigarettes? ☐ Yes ☒ No
2. Have you been employed full-time with your present employer for at least the past 5 years with a separate residence and business location during that time? ☒ Yes ☐ No
3. Do you agree to pay premium for the policy on an annual basis? ☐ Yes ☒ No

Each of the foregoing answers are correctly written, as given by me, and are true and complete to the best of my knowledge and belief.

Christopher L. Kearney 4-8-91
Proposed Insured Date

Daniel P. Shinn
Agent

ST. LOUIS, MO

RIDER PROVIDING CHANGES IN BENEFITS

The Policy to which this Rider is attached is hereby amended by making the changes listed below:

Loss of Sight, Speech or Use of Two Members: This provision is changed by adding "Total and irrecoverable loss of hearing in both ears" to the occurrences for which benefits will be paid under this provision.

Except as provided herein, this Rider shall not otherwise vary, alter or extend any of the terms of the policy.

This Rider is hereby made a part of the policy to which it is attached. It takes effect and expires at the same time as the policy.

JEFFERSON-PILOT LIFE INSURANCE COMPANY


Secretary

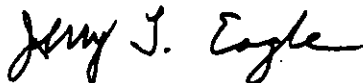
RIDER ADDING BENEFITS FOR PREGNANCY

The policy to which this Rider is attached is amended as follows:

- (1) Exclusion (4), "normal pregnancy or resulting childbirth" is hereby deleted; and
- (2) the Benefits For Total Disability Due To Sickness shall include pregnancy as any other Sickness.

This Rider shall not otherwise vary, alter or extend the terms of the policy. It becomes effective and terminates at the same time as the policy.

JEFFERSON-PILOT LIFE INSURANCE COMPANY


Secretary

AMEN

**RIDER CHANGING THE DEFINITION OF TOTAL DISABILITY
APPLICABLE TO OCCUPATIONAL CLASS AAAAAA OR AAAAA**

This Rider amends the policy to which it is attached. It amends the policy by deleting the definition of "Total Disability" and substituting the following therefor:

"Total Disability" means that you are unable to perform the duties of your occupation. Your occupation means:

- (1) during the elimination period and prior to your fifty fifth birthday or for the first five years of a period of disability, whichever is greater, the occupation in which you are regularly engaged at the time you become disabled; and
- (2) thereafter, any gainful occupation in which you might reasonably be expected to engage because of your education, training or experience.

This Rider shall not otherwise vary, alter or extend the terms of the policy. It becomes effective and terminates at the same time as the policy.

JEFFERSON-PILOT LIFE INSURANCE COMPANY


Secretary

WJ-1955

EXHIBIT

**Notice Concerning Coverage Limitations
And Exclusions Under The Ohio Life And
Health Insurance Guaranty Association Act**

**Jafferson
Phoi**

Residents of Ohio who purchase life insurance, annuities, or health insurance should know that the Ohio insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Guaranty Association. The purpose of this association is to assure that policy-holders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Ohio Life and Health
Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, OH 43220

Ohio Department of
Insurance
2100 Stella Court
Columbus, Ohio 43266

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

(continued)

NOT FOR MEN

Coverage

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policy holder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contracts sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limits On Amount Of Coverage

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits, \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401(k), 403(b) or 457 of the Internal Revenue Code, the limit is \$100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contractholder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

ST. LOUIS

Statutory Rider

**Jefferson
Pilot**

The Policy to which this Rider is attached is hereby amended as follows:

You may cancel this Policy at any time by written notice delivered or mailed to Jefferson-Pilot. The effective date of the cancellation will be the date Jefferson-Pilot receives such notice or the date you specify in your notice, if later. Jefferson-Pilot will promptly return the pro rata portion of any unearned premium paid for any period beyond the cancellation date. Cancellation shall be without prejudice to any claim that begins prior to the effective date of cancellation.

This Rider is hereby made a part of the Policy to which it is attached. It takes effect and expires at the same time as the Policy.

Jefferson-Pilot
Life Insurance Company

Secretary

MEN

Policy No. E-538069 Effective May 28, 1991

(BANK DRAFT PRIVILEGE)

Premiums for this Policy may be paid by bank draft in equal payments of \$ 59.36 each, due on the 28th day of each month beginning with the date of this rider. Notice of any premium due under this Policy is hereby expressly waived so long as premiums are being paid under this privilege, but the sending of notices by the Company may be commenced or discontinued at any time and without notice to the premium payer, without creating any obligation on the part of the Company as to sending premium notices.

If any draft or check is returned unpaid on account of insufficient funds, this privilege shall terminate at the option of the Company, and future premium payments shall be paid direct to the Company. Upon termination of this privilege, the method of payment and the amount of premiums shall be changed to the most frequent regular basis of premium payment computed at the applicable premium rate and which results in a premium not less than the minimum premium then being accepted by the Company.

This rider in no way affects the Renewal Provision in the Policy.

JEFFERSON-PILOT LIFE INSURANCE COMPANY

Jerry I. Eagle

Secretary

The following provision becomes a part of the Section of the policy captioned "Benefit Provisions".

SOCIAL SECURITY SUPPLEMENT

The Monthly Benefit of this policy will be increased by the amount of the Social Security Supplement Benefit shown in the Schedule if:

- (1) you are entitled to receive Monthly Benefits for Total Disability;
- (2) the period of Total Disability begins prior to the premium due date of this policy next following your 65th birthday; and
- (3) Social Security Benefits are not payable.

However, the Social Security Supplement Benefit shall not be payable unless:

- (1) at the commencement of the period of Total Disability you meet the coverage requirements for Social Security;
- (2) you apply for Social Security Benefits as soon as you become entitled to such; and
- (3) your application for Social Security Benefits is not approved.

Following a denial of your application for Social Security Benefits you must within 30 days of the date on which each such request can be filed, file a request for reconsideration, a hearing or an appeal.

You may convert the amount of the Social Security Supplement Benefit to a regular Monthly Benefit if:

- (1) you become ineligible for benefits under the Social Security Act of the United States; or
- (2) benefits are drastically reduced by Legislation.

The conversion will be the subject to Jefferson-Pilot's then current underwriting rules with respect to the relationship of earnings to total benefit amounts for disability.

For the purposes of the General Provisions of this policy captioned "Proof of Loss", written proof will included, but not be limited to, the correspondence between you and the Social Security Administration.

The premium for the above benefit is included in the premium shown in the Schedule.

EXHIBIT

The following provision becomes a part of the section of the policy called "Benefit Provisions".

RESIDUAL DISABILITY

(Nothing in this Provision limits the policy definition of "Total Disability")

Additional Definitions

"Residual Disability" means you are:

- (a) unable to do one or more of the substantial and material duties of your profession; or
- (b) unable to do your usual daily business duties for substantially as much time as is usually required to do such duties.

"Monthly Income" means:

- (a) monthly income from salary, wages, bonuses, commissions, fees or other remuneration earned from services rendered which are;
- (b) exclusive of normal and customary business expenses but before deduction of income taxes.

It does not include dividends, rents, royalties, annuities or other forms of unearned income.

"Prior Monthly Income" means the greater of your:

- (a) average Monthly Income during the 12 months just prior to the period of disability for which you are making claim; or
- (b) average Monthly Income during the calendar year just prior to that period of disability.

But any such Monthly Income in excess of \$15,000 will not be used as Prior Monthly Income.

The "Prior Monthly Income" will be adjusted at the same time and by the same percentage as the "Increase in Benefits" or "Increase in Benefits for Total Disability" provision, whichever is applicable, of this policy.

"Current Monthly Income" means your Monthly Income during each month of Residual Disability for which you make your claim.

"Loss of Monthly Income" means the difference between Prior Monthly Income and Current Monthly Income. Any Loss of Monthly Income of more than 75% of the Prior Monthly Income will be deemed to be 100%.

"Monthly Benefit" is the amount shown in the Schedule as such.

"Residual Disability Monthly Benefit" is the benefit payable for each month of Residual Disability. It will be figured monthly as follows:

$$\frac{\text{Loss of Monthly Income}}{\text{Prior Monthly Income}} \times \text{Monthly Benefit} = \text{Residual Disability Monthly Benefit}$$

The Premium for this benefit is included in the premium shown in the Schedule.

Residual Disability Benefit

Jefferson-Pilot will periodically pay the Residual Disability Monthly Benefit if:

- (a) Injury or Sickness results in Residual Disability;
- (b) the Residual Disability starts before the premium due date of this policy on or next following your 65th birthday.

This benefit will begin:

- (a) the next day after the end of the Elimination Period shown in the Schedule; or
- (b) the next day after the end of a period for which Total Disability has become payable, if later.

During a period of Residual Disability, Jefferson-Pilot will continue to pay the Residual Disability Monthly Benefit for each month you are Residually Disabled until the combination of Total Disability and Residual Disability Benefits equal the Maximum Benefit Period. However, the Residual Benefit will not be paid for longer than 24 months if:

- (a) you were 55 years old or older when the period of disability began; and
- (b) Residual Disability is not preceded by at least 180 days of Total Disability due to the same or related cause.

Benefits paid for the first 6 months of Residual Disability will be the greater of:

- (a) 50% of the Monthly Benefit for Total Disability; or
- (b) the Residual Disability Monthly Benefit.

Limitations

The Residual Disability Benefit will not be paid for any period of time:

- (a) during which your Loss of Monthly Income is not at least 20% of your Prior Monthly Income.
- (b) that you are not under the care and attendance of a Doctor; or
- (c) that benefits are payable for Total Disability or loss of sight, speech, hearing, or use of two members.

Jefferson-Pilot may require you to present reasonable proof of your Current Monthly Income and your Prior Monthly Income.

Insert C

MEN

ADDITIONAL INCREASE IN BENEFITS RIDER

Policy Number _____

Effective Date (if different from Effective Date of Policy) _____

Initial Premium (unless included in the Schedule of Insurance) _____

In consideration of the increased premium for this Rider, the policy referred to above is hereby amended by changing from 3% to 7% the percentage shown in the benefit provision captioned "Increase in Benefits."

This Rider becomes effective at the same time as the policy unless otherwise stated above.

This Rider terminates:

- (1) When the policy terminates; or
- (2) On the first premium due date after your 65th birthday.

All provisions of your policy remain the same except where they are changed by this Rider.

PILOT LIFE INSURANCE COMPANY

W Linville Roach
Secretary

SPECIMEN